

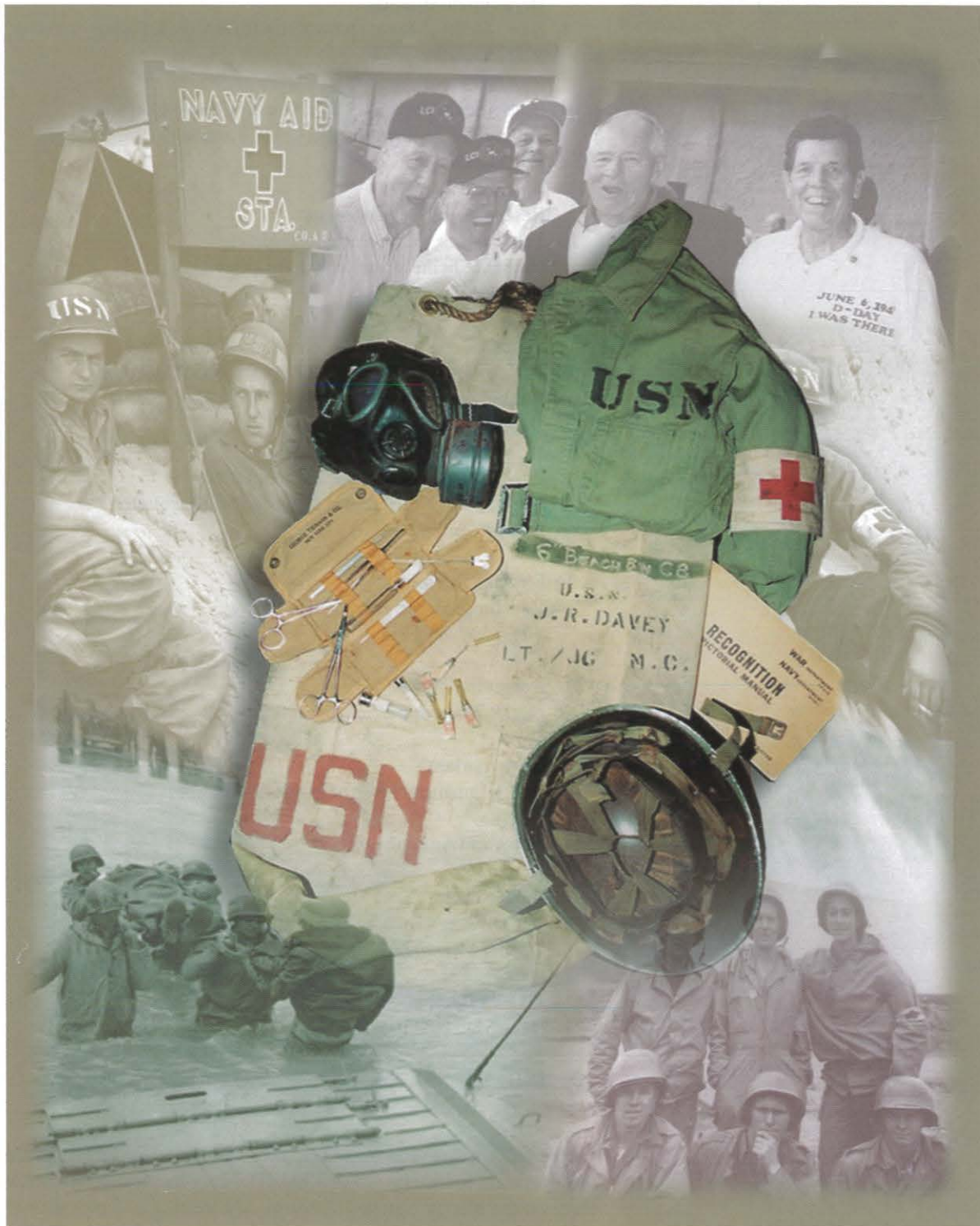
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# NAVY MEDICINE

November - December 2000





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# NAVY MEDICINE

Vol. 91, No. 6  
November-December 2000

## Department Rounds

- 1 Navy Medical Team Helps Keep Blue Angels Flying  
*Rod Duren*
- 4 Blue Angels Chemistry and 'Cresting' Give Corpsmen Yellow-Gear Mentality, and C/MC Reason to Brag  
*Rod Duren*

## Research and Development

- 13 The Business of Research: Protecting Navy Medicine's Intellectual Property  
*Doris M. Ryan*

## Features

- 5 A New Lease on Life: The First U.S. Naval Hospital Washington, DC  
*Daniel S. Donahue*
- 8 The 6th Naval Beach Battalion in France Presidential Unit Citation Awarded 56 Years Later  
*Kenneth C. Davey*
- 16 Frozen in Memory: Recalling Chosin Reservoir  
*Henry Litvin, M.D.*
- 22 Achieving Wellness  
*LCDR Josephine Brumit, NC, USN*
- 24 In Memoriam  
CAPT Emanuel Navarro Buckley, MSC

## Notes and Announcements

## Book Review

- 25 The Dragon's Breath: Hurricane at Sea  
*LT Y.H. Aboul-Enein, MSC, USN*

## A Look Back

- 29 Navy Medicine 1954
- 26 INDEX Vol. 91, Nos. 1-6, January-December 2000

**COVER:** Fifty-six years ago Allied forces mounted the largest amphibious operation in history—OVERLORD. Navy medical personnel were there on the bloody beaches of Normandy treating and evacuating the wounded. A tribute to these unsung heroes appears on page 8. Cover art by Sally Hobson, NSHS, Bethesda, MD.



# Navy Medical Team Helps Keep Blue Angels Flying

Rod Duren

**T**hey are a medical team working with the most popular flight team in the Navy, yet these care providers can be found turning wrenches or checking a hydraulic line as well as dispensing medications or taking temperatures.

They are the doctor and hospital corpsmen assigned to the Blue Angels flight demonstration team, and their medical practice is different than those at other medical commands.

"Because they scream across the sky at supersonic speeds, seemingly almost scraping the paint off each others aircraft, we must keep them as healthy as we can all the time," said Flight Surgeon LCDR Pat McMahon, MC, who travels with the Blues as its medical officer. The doctor also critiques each of the performances during the 9-month season.

McMahon is joined by at least one of two hospital corpsmen on the road with the Blues. Either HM2 Corey Coldiron, from Winterset, IA, or HM3 Jack Blaine from Trinidad, CA, both specialists in aerospace medicine, will travel with the team while the other remains in Pensacola to care for the non- traveling Blue Angels staff.

"It is a great job," said McMahon, a 1992 Uniformed Services University of the Health Sciences medical school graduate. "It is even better than I thought it would be."

McMahon has served with numerous Navy and Marine Corps aviation squadrons, and while stationed at Naval Air Station New Orleans he was selected the 1996 Commander Naval Reserve Forces Flight Surgeon of the Year. In 1998, he was selected as a member of the Department of Defense National Aeronautics and Space Administration (NASA) medical support team. "The Blue Angels are a special fraternity ... a unique breed of naval

aviators," says McMahon, who, as the flight surgeon, must know the stressors of these pilots. One of the lessons learned in flight surgery training at the Naval Operational



Photos courtesy of the author

Blue Angels pilot and events coordinator MAJ Bruce Shank of La Canada, CA, (left) gets a medical evaluation from flight surgeon, LCDR McMahon.

Medicine Institute in Pensacola was to try and know them from a psychological standpoint. But the bottom line is to "be a friend first," he insists, "because few people come to a doctor (for help), but they will come to a friend."

To become a good flight surgeon for the Blues "you have got to be willing to help" not only during working hours but on personal time as well, he says.

Being willing to help is not just a nice thing with the Blues. It is mandatory. Because being a hospital corpsman, especially on the road at "the show" is more like collateral duty, says Coldiron. "We become part of the maintenance team."

So, what does a corpsman know about maintaining finely honed jets that thrill millions of people around the world? "The jets come first," says Blaine. "It is all about putting on the show."

Being an aviation medical technician in the squadron means being part of the overall unit, according to first-year team member Blaine. They do not have to medically take care of people all the time, but that does not mean the corpsmen are given a pass to sit on our duffs while everybody else is working their tails off.

"We have to assist wherever possible, and that is fine with us," says Blaine.

"If that means a hospital corpsman works with the maintenance crew on the F/A-18s or 'Fat Albert, the Marine Corps' C-130 Hercules transport aircraft, then that is what we do," continues Blaine.

"Even if that assistance means just handing someone a wrench or wiping down the aircraft's windshield, which is lovingly called show cleaning, we do it," continues Coldiron.

But the maintenance chiefs know that the hospital corpsmen are not certified jet engine mechanics. Blaine says they teach the corpsmen some aspects of hydraulics and engine servicing. "We do not actually do maintenance...we assist," he says. Coldiron has a fascination with the intricacies of maintaining these multi-million dollar aircraft. "I just like to go out there and get dirty," he says. The Iowa corpsman's father, a former Navy jet mechanic, died when Corey was three years old. But he says, "I think he would have been proud to know that I followed in his foot

steps and joined the Navy"...and dabble as an aircraft mechanic.

But often enough, the hospital corpsmen ply their trade in a narrow, one-room medical facility inside hangar 1852 on the west end of Naval Air Station Pensacola at Sherman Field. From their mini-clinic, they keep the entire squadron healthy. They act as liaison for any dental or advanced medical care, and in addition, they perform annual physical examinations on each of the pilots and aircrew.

They are also responsible for keeping personnel medical readiness up-to-date, treating sick or injured staff and performing emergency medical procedures as needed.

"We have an open-door sick call policy," says Coldiron. "We see patients here all day along," he continues while dispensing an over-the-counter medication to Aviation Storekeeper 2nd Class Jenn Kessler, a member of the Blue Angels' supply department. On the road at air shows, the hospital corpsmen hold sick call from their rental vehicles.

Coldiron and Blaine also review the crews' medical records, keep them updated on required inoculations and assist Dr. McMahon in minor surgical procedures.

On the road, the hospital corpsmen often—because they have a 'medical' designated vehicle—will drive the Blue Angel pilots to their aircraft. "You do not talk to the



Blaine, Coldiron, and "Fat Albert," the Blues' C-130 support aircraft.



pilots on show day," says Coldiron. "Unless spoken to first," chimes in Blaine. "That is because their minds are on the show," continues Coldiron, who has previous experience with pilots while serving with VFA-131 at Cecil Field in Jacksonville, Fla.

The Blue Angels have flown all over the world, and it is a great experience say both corpsmen. As they rotate their turns going on the road, each gets an eyeful of the Blue Angels mystique and also gains a healthy respect for others as McMahon leads the contingent on visits to local children's hospitals.

"The response from people is awesome," says Blaine, when they show up at the hospitals in their blue flight suits, especially "when you see the kids' eyes glowing (at the sight of the blue uniforms) ... just as I did as a little kid. Now, I am on the other side of the fence. But really, we're just doing a job. We put our pants on the same as everyone else," he says modestly.

"The pilots are the stars," continues Coldiron. "There is nothing special about us. We just make sure the (maintenance) crew is well, and that they can work on the (pilots') aircraft if necessary."

But whether you are a pilot, aircrew or member of the ground crew—or the medical team—being a part of the Blue Angels is not a matter of getting an everyday assignment. On the flight uniforms of each member of the squadron is a blue and gold logo that covers a rather large portion on the right-hand side of the chest area. These patches are not handed out to new squadron arrivals. They must be earned. 'Newbies'—which is among the favorite of words around the squadron—have to go through a Personnel Qualification Standards program—called 'cresting'—that lasts four months. Squadron members learn hydraulic servicing, how to tow aircraft, the names of each commanding officer in Blues history since its inception in 1946, and fueling techniques, among other lessons. "You have got to learn everything there is to know about the Blue Angels," says Coldiron. Then, a newbie must go before a review board, and pass a 130- question written examination. "It was the proudest day when I got to put on the crest," says Coldiron. "It gave me great pride,"

continues Blaine, who also has experience with a deployable unit, VAQ-137, based out of Whidbey Island, WA. "This is an elite team," continues Blaine, "but (if a hospital corpsman) has the desire and qualifications then this billet is open-ended. Five years ago, I never would have thought I would be a part of the Blue Angels team."

In late fall, a new Blues' flight surgeon will come on board, along with possibly a new aviation medical technician. McMahon will break in the newbies during the final month of this year's season before sending the contingent to El Centro, CA, for the winter training regimen, from January to March, to prepare for the 2001 season. "It is a great feeling to represent Navy medicine as part of an aviation team known around the world," says McMahon. "We have a tremendous responsibility to see that these aircrews and support personnel stay healthy. The hospital corpsmen and I are proud to do that." □

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Rod Duren is Public Affairs Officer at Naval Hospital Pensacola, FL



Blue Angels' flight engineer, GYSGT Reid Henderson (far left) explains a piece of aviation equipment with flight mechanic GYSGT Mike Perry, Jr., and (far right) crew chief AD1 Alfredo Acevedo. Hospital corpsmen Jack Blaine and Corey Coldiron listen and learn.



## BLUE ANGELS CHEMISTRY AND 'CRESTING' GIVE CORPSMEN YELLOW-GEAR MENTALITY, AND C/MC REASON TO BRAG

Naval Hospital Pensacola has a Journalist. The Blue Angels have a Hospital Corpsman. Go figure! There's only a handful of Master Chief Hospital Corpsmen (HMCM) who are Command Master Chiefs (C/MC) of operational squadrons.

HMCM(AW/FMF) Paul Orr, a 26-year Navy corpsman, is C/MC for the Navy Flight Demonstration Squadron, an operational squadron better known as the Blue Angels.

The C/MC has an active career, having served and/or been involved with seven aircraft carriers, 100 squadrons, 14 shore installations plus being the Force Corpsman at Commander, Naval Air Force, Atlantic. As the Command Master Chief of the Blue Angels, this Virginia Beach, VA, sailor knows the 110 Navy and Marine Corps enlisted personnel are among the "best of the best." However, being a mediator between all of these Type-A personalities is not the easiest job in the world, but it may be one of the more satisfying.

He is particularly proud of the hospital corpsmen assigned to the Blue Angels' medical department—HM2 Corey Coldiron and HM3 Jack Blaine. C/MC Orr is equally complimentary of the squadron's flight surgeon, LCDR Pat McMahon, who he calls a fine naval officer and doctor, and a "real people-person." The corpsmen get to practice medicine, much like they did when they were with their previous operational squadrons. But it is more like a "family medicine program," insists HMCM Orr. It is a close-knit community in which one-third of the "team" turns over each year.

The number of opportunities for corpsmen are vast, says Orr. Being a 'team player' means having to know a good deal about the jets and C-130 transport aircraft. The people selected for the billets at the Navy Flight Demonstration Squadron are "handpicked ... and are the cream of the crop, the best in their subspecialty," says the C/MC. They cross-train, "wearing four or five different hats," while on the tarmac with the maintenance crews or in-house with the logistics personnel.

It is not unusual to see corpsmen on the flight line with the yellow gear at 0300 assisting maintenance crews with fueling, towing, or servicing jet engines. Yellow gear refers to the aircraft support equipment. The Blue Angels' maintenance staff—from the crew chief to the corpsmen—"turn these jets upside down" in preflight inspections, meaning the only thing left for the "pilots

is to get in and fly," he says. "Nowhere else in the Navy is that done," touts Orr. "It is incredibly demanding. Never have I ever seen a corpsman have this kind of opportunity."

Navy squadron pilots generally do their own preflight inspections. Earning the Blue Angels crest is something special for each team member. 'Newbies' go through a 4-month hands-on and study regimen that is similar to going on a deployment, he says. The staff works 6 days a week beginning at 0-dark-30. "On Sundays, you have got just enough time to go to church, catch a cat nap and do your laundry before starting over again at 0300 Monday," the master chief quips.

Selection to the HM billets is based on having "the right chemistry" and aerospace medicine background, insists HMCM Orr who arrived with the Blues in August 1999. Corpsmen who may aspire to this type of opportunity need to go to aerospace medicine school at Naval Operational Medicine Institute in Pensacola. It provides a basic foundation for the skills one will need for a tour with any operational aviation squadron. "Until you apply for one of the special programs," says the C/MC, "you will never know how good you are. Everyone needs to take the opportunity to apply for any of these programs" (recruiting, company commander, Blue Angels).

"I take a great deal of pride in our corpsmen," the Blue Angels' senior enlisted advisor continues, and "I will encourage them when they leave to apply (for one of the) commissioning programs or IDC (Independent Duty Corpsman training). Three years with the team," he says, "all of this diverse training will make them very competitive in those fields."

The C/MC says his focus is on the "precious commodity" of 110 personnel, and their families, with the squadron. He does not always travel with the team during show season. Generally speaking, he acts—especially during this first year of a new admin officer—essentially as an executive officer for the squadron, coordinating the wardroom and working closely as a liaison between the staff to the Commanding Officer, CDR Patrick Driscoll. "As a Blue Angel, you are a premier ambassador for the Navy and Marine Corps," the former C/MC of Naval Hospital Okinawa and the Third Marine Division says. "It is a privilege and an honor to serve with these young people."

—Rod Duren



# A New Lease on Life: The First U.S. Naval Hospital Washington, DC

Daniel S. Donahue

**T**he three-story 20,000 square foot red brick building, and two-story carriage house that sits on a triangular lot at 9th and Pennsylvania Avenue Southeast, is the first permanent U.S. Naval Hospital in Washington, DC.

At the request of President Abraham Lincoln, on 14 March 1864, the Congress appropriated \$25,000 for the construction of the first U.S. Naval Hospital in the nation's capital. Prior to that, the Navy used a decentralized system of temporary facilities at the Marine Corps Barracks, several wards of the Government Hospital for the Insane, a small dispensary at the Navy Yard, and an apothecary in a townhouse across the street from the future Naval Hospital. The naval hospital was located within easy walking distance of the Marine Corps Barracks and the Washington Navy Yard.

The first Naval Hospital, gatehouse, and fence was completed in July 1866 at a cost of \$114,000 and commissioned on 1 October of the same year. The considerable overrun was due to the post Civil War scarcity of building materials and fragmented transportation lines.

As designed, the Old Naval Hospital is a fine example of Italianate, Greek revival, and Second Empire architectural styles. The short-armed cross-shaped main building facing southward is 60 feet deep by 90 feet long. As built, the hospital includes a basement, two stories, and an attic under a mansard slate roof.

The Old Naval Hospital's main exterior architectural features are four chimneys, eaves, cornices, and dormers. Wide decorative cast iron stairs lead up to the south entrance, a columned wooden porch. The north entrance is



Photo by Incl Bowman

The old Navy Hospital today.

a smaller cast iron porch with a grilled trellis supporting a bell roof. An ornamental cast iron gazebo covers one of the two wells on the property. A two-story gatehouse is situated on the western edge of the hospital grounds.

Once the Old Naval Hospital gardens blazed with dogwoods, tulips, iris, lilies, and roses on a three-quarter acre shaded lot. A 20-foot flagpole, ship's bell, and anchor were typical military site features of days gone by. A Civil War era cannon and two large piles of cannon balls provided additional security as did a stout 7-foot-high cast iron fence with remarkably trimmed gates, detailed square columns, and posts.

The first and second floors have 14-foot ceilings with many large rectangular recessed sash windows providing ample natural light, solar heating, and excellent ventilation. The rooms and wards open onto a wide central cor-

ridor. Connecting the east and west wings, a smaller passageway extends the length of the hospital, crossing at mid point dividing the first and second floors into four sections. The first floor contained a receiving area, administrative offices, mess, duty officer's quarters, and waiting and examination rooms.

The second floor is the main hospital treatment area that included the officers' ward, nurses' station, dispensary, water closets, and four enlisted wards. The third floor has two spacious wards with water closets separated by a nursing station and the terminus of the stairwell. Seven separate below-grade entrances lead into the basement support area containing the boiler room, coal bunker, laundry, apothecary's quarters, three-cell brig, storekeeper's area, kitchen and scullery, and a dumbwaiter.

Two-foot-thick exterior brick walls as well as the 1-foot-thick interior supporting walls act as effective insulators. The 14-foot-high interior plaster walls have the original functional ventilation grates and early radiators serviced by a coal-fired steam boiler. Period wood paneled doors, woodwork trims, door transoms and some of the original hardware are intact, albeit worn and damaged. The wainscoted oak stairwell, steps, and balustrade are sturdy and well preserved. The floors are the original Georgia white pine planking now covered with carpets and composite floor tiles.

As originally built, Washington's first permanent naval hospital was designed to accommodate 50 ailing Sailors and Marines. However, the hospital's medical wards treated as many as 63 patients simultaneously. The Old Naval Hospital quickly grew to care for an annual average of 110 patients.

From 12 July 1866 until 3 February 1911, 20 commanding officers served the medical needs of the Potomac River Naval Command, Washington Navy Yard and the U. S. Marine Corps Barracks. Naval Surgeon Dr. Charles D. Maxwell was the first commanding officer, serving from 1866 to 1868. Dr. Maxwell's responsibility was to skipper the hospital's final construction phase and shake-down cruise. In addition, Dr. Maxwell sought and secured supplemental funding from the sparse post Civil War Navy Department budget for needed medical support improvements not included in the initial construction phase.

Dr. Maxwell recognized that Anacostia River water was scarcely suitable for bathing, and completely useless for patient care. He designed and supervised the installation of the water purification system, which pumped water into two 1000-gallon iron water tanks in the attic. Passing

the river water through a Loomis filter rendered the water potable. Dr. Maxwell also upgraded the sanitary conditions by replacing all the water closets and adding washbasin sinks.

Shortly after Dr. Maxwell's retirement on 21 October 1868, the Navy Department assigned the Naval Hospital to the Commandant of the Washington Navy Yard. The Secretary of the Navy's standing orders to the Commandant of the Yard was to treat any "Officer, Seaman, Marine or Private of the U.S. Naval Service."

The first patient admitted to the Naval Hospital on 1 October 1866 was "Ordinary Seaman Benjamin Drummond, Colored, a New York native and 24 years of age." Seaman Drummond suffered a gunshot wound in his left leg, in the line of duty. Drummond was stationed on board the square-rigged blockade ship *Morning Light* when it was captured by Confederate forces at the Battle of Sabine Pass, TX, on 7 January 1863. Interned in a Texas prisoner of war camp with a small unhealed wound, he managed to escape to the safety of Union lines and was eventually admitted on 27 June 1866 to the U.S. Naval Hospital at Annapolis, MD. Seaman Drummond was transferred and treated at the temporary Naval Hospital at the Insane Asylum Washington, until it closed on 1 October 1866. Seaman Drummond was discharged, on 23 March 1868, at 50 percent disability upon expiration of his enlistment. According to his final medical report "His wound was quite relieved."

The elegant structure at 9th and Pennsylvania Avenue, SE served as a naval hospital until 1902. Early that year, after 36 years of humanitarian service, the Old Naval Hospital was deemed inadequate, antiquated, and insufficient to conform to the conditions of a modern hospital's requirements. From 1902 to 1907 the building operated as a medical clinic and a quarantine ward.

Electric and telephone service and an icebox were added to modernize the Old Naval Hospital in 1907. Accommodating the dual purpose of the Naval Hospital Annex and the Hospital Corps Training School, some of the first floor was modified for a reading room, library, and lecture hall fitted with benches, chalkboards, and lockers. The two second-floor wards were converted to dormitories, complete with shipboard style iron framed hammock racks. The basement renovation included large modern kitchen equipment and a 60-man dining room.

The Naval Medical School at Norfolk, VA, was temporarily transferred to the Naval Hospital. On 1 October 1907, Class No.14 began training the first of the 600 enlisted hospital corpsman for Fleet duty and assignment to



the new Naval Hospital Washington, DC, under construction at the present site of the Bureau of Medicine and Surgery (BUMED), and the old Naval Observatory at 23rd and E Streets, NW.

In 1909 the property was considered unsuitable for the training school. The main difficulty was a lack of ample grounds for military drilling and medical training exercises. In addition, the nearness of other buildings and easy egress from the grounds promoted mischief among the young sailors. On 1 February 1911, the Old Naval Hospital Medical School graduated its last class on the centennial anniversary of the passage of U.S. Naval Hospital Authorization Act.

On 3 February 1911, the Old Naval Hospital was downsized and detailed to care for infectious disease cases and the overflow from the yet unfinished wards of the new Naval hospital.

The Old Naval Hospital remained on active duty for the next 11 years operating as a medical clinic conducting World War I recruiting physicals, the Navy's Reserve Force Office, and a Navy Records and Clerical Center.

The Old Naval Hospital has played a prominent role in Navy medicine, is the oldest documented naval hospital in Washington, and was the first naval hospital designed on a large enough scale to serve for an extended period. As one walks the hallowed halls, one can visualize the building's original use as a hospital.

In 1964 the building was listed on the DC Joint Commission of Landmarks. In 1974, the Old Naval Hospital exterior was designated a National Historic Landmark and placed on the Department of the Interior National Register of Historic Places. Although the historically significant interior of the Old Naval Hospital remains unprotected from regulated renovation, the building is on the DC Preservation League's list of Washington's 10 Most Endangered Historic Structures. Despite wear and tear, the Old Naval Hospital is structurally intact, but is a monument to neglect and continued abuse.

The U.S. Government owns the Old Naval Hospital and currently leases it to the DC Government, which has had stewardship of the building since 1963. Located in the Capitol Hill Historic District, the building is a historically relevant and architecturally prominent landmark. While it retains its architectural integrity and, albeit damaged honor, the building still remains as visually impressive as it did in 1866.

Admired, abused, and ignored for years, the Old Naval Hospital is currently under consideration as the prime candidate for the "Official Residence of the Mayor of the

District of Columbia." DC Act 13-390 is currently before Congress. If passed, the act will authorize the District of Columbia Commission to explore acquisition of title to the Old Naval Hospital.

Navy medicine has a history rich in accomplishment and tradition. Navy medical personnel have made distinct contributions, since the beginning of the Revolutionary War to the long duration stay of CAPT J. M. Linenger, MC, USN, aboard the Mir Space Station in 1997.

Navy medicine has neither a memorial to its distinguished past nor a central repository for its documents and artifacts. The Naval Medical Museum and Navy Medicine Memorial Foundation, a small but growing group of Navy and Marine Corps veterans and everyday citizens, are exploring the possibility of establishing a Naval Medical Museum and a Navy Medicine Memorial on the site of the Old Naval Hospital. The establishment of the Naval Medical Museum will encourage tourism, promote educational opportunities and activities, as well as enhance national, civic, cultural, and Navy pride. The Naval Medical Museum will provide exhibit space, visual arts programs, personal collections archives, naval medical history seminars, and a conference center.

The first U.S. Naval Hospital, Washington, DC, is cherished and hallowed ground to many active duty and veterans of all the corps within the Navy Medical Department. It is an unequaled and befitting locale to honor the sacrifices, heroic deeds, memories, and accomplishments of those dedicated men and women of Navy medicine who have served unselfishly to safeguard the personnel of the Navy and Marine Corps.

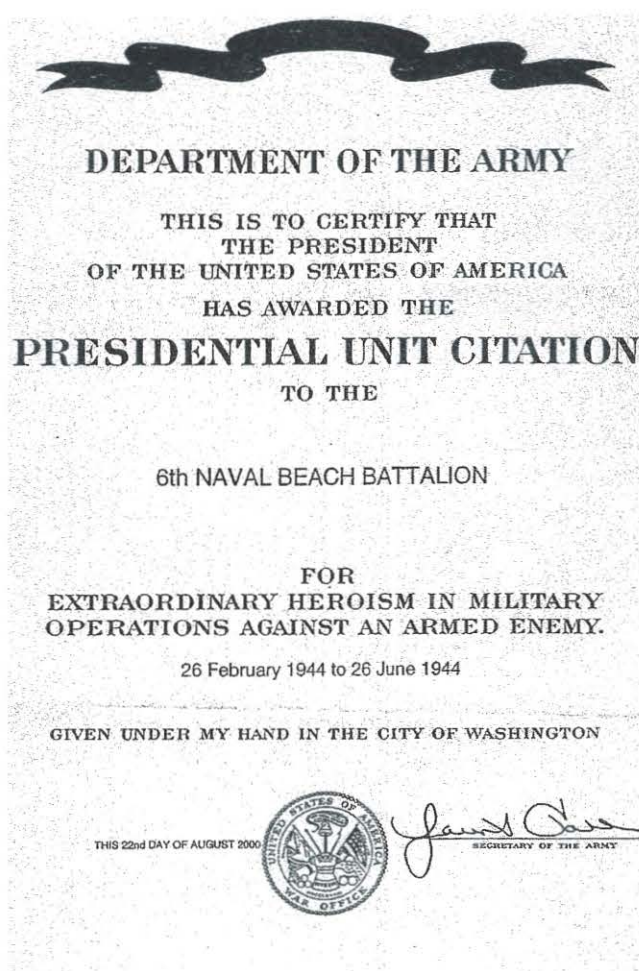
A rare opportunity exists to combine the historic Old Naval Hospital with the Naval Medical Museum and Navy Medicine Memorial on this hallowed ground. The Naval Medical Museum and Navy Medicine Memorial Foundation are working hard to accomplish this daunting task. For more information visit our website at [www.navalmedicalmuseum.org](http://www.navalmedicalmuseum.org) or contact us at Naval Medical Museum, P. O. Box 15311, Washington, DC 20003-0311, (202) 529-3700. □

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Mr. Donahue is a former Navy dental technician and founder of the Navy Medical Museum and Navy Medicine Memorial.

# The 6th Naval Beach Battalion in France

Kenneth C. Davey



*Presidential Unit Citation  
Awarded 56 Years Later*



COL Meridith Temple, USA, Commanding Officer of the 18th Airborne Corps (G-3), presents the Presidential Unit Citation to veterans of the 6th Naval Beach Battalion, (l to r) Joseph Vaghi, Vincent Kordack, and Ed Marriott.



Photo by the Editor

On 6 June 1994, half a century after the Allied invasion of Normandy, a U.S. Army D-Day veteran remarked that the most horrendous invasion sight was a beach battalion bulldozer moving bodies to make roads off the Easy Red sector of Omaha Beach. "A most heroic sight was that of a Navy Beachmaster calmly walking along the beach issuing orders through a bull-horn." Several hours earlier, Beachmaster Joe Vaghi had used that powered megaphone to pass along the final attack order, exhorting the 1st Division assault troops to capture the beach exits above Easy Red.

Army D-Day commanders on the invasion beach described the valor of the Navy bulldozer operator and the Beachmaster's entire battalion in a proposed Unit Citation: "The extraordinary gallantry, heroism, and determination displayed in overcoming unusual difficulties and hazardous conditions and the esprit de corps displayed by the 6th Naval Beach Battalion contributed materially to

the capture of Omaha Beach and reflect highest credit on personnel of this organization and the Armed Forces of the United States." RADM Alan G. Kirk, Commander of the Western Naval Task Force in France, recommended approval of the Unit Citation on 26 February 1945. For reasons unknown, the battalion did not receive the award.

The 6th Naval Beach Battalion (NBB) began going ashore the invasion beaches of Normandy during the early morning hours on D-Day, 6 June 1944. At H+65 minutes, approximately 1 hour after the first man stepped onto the beach, CDR Eugene Carusi, Beachmaster Vaghi, a young Navy doctor, and 45 amphibious sailors of the battalion disembarked from the U.S. Coast Guard-manned LCI(L)-88—a Landing Craft Infantry (Large)—and struggled ashore the Easy Red sector of Omaha Beach. As naval elements attached to the Army's 5th Engineer Special Brigade, the mission of these World War II sailors was to prepare the beachhead, provide medical aid for the early wounded, and keep men and materiel moving across the beach.

Once ashore, the 6th Naval Beach Battalion became the vital link between land and sea forces in the St. Laurent-Colleville area of Normandy. The 400-man Navy battalion, composed of three companies, including three platoons within each company, organized the Omaha landings in the invasion sectors code-named Easy Red, Fox Green, and Fox Red. The commander of each platoon was a Beachmaster, whose duties have often been described as similar to a traffic cop at a busy intersection in hell. Utilizing hydrographic sailors for beach reconnaissance and demolition, a communications section, boat repair specialists, a medical doctor, and Navy hospital corpsmen of the platoon, the Beachmaster controlled all boat traffic coming onto the beach and arranged for the shore-to-ship evacuation of the casualties.

Unfortunately, not all of the Navy Beachmasters and their men made it ashore the Easy Red sector of Omaha Beach. At approximately 0830 on the morning of D-Day, "We could hear the screams of men through the voice tube" reported LTJG Coit T. Hendley, Jr., USCGR, commanding officer of LCI(L)-85. The '88's were hitting the ship. "The shells tore into the troop compartments. They exploded on the exposed deck. They smashed through massed men trying to get down the ramp. Machine guns opened up." The landing craft had been hit about 25 times, killing Beachmaster Jack Hagerty, Beachmaster G. E. Wade, Assistant Beachmaster Len Lewis, Navy corpsmen, battalion radiomen, and Army combat engineers. "Unloading of the Coast Guard-manned LCI-85 had to be stopped because the living could not climb over the dead."



LCIs (Landing Craft Infantry) unload troops on invasion beach.

U.S. Navy Beachmaster Joseph P. Vaghi explains the worth of invasion money to villagers of St. Laurent-sur-Mer.



Photo courtesy of the author

Medical personnel prepare to load a casualty aboard a departing landing craft.



BUMED Archives



The beach battalion doctors went to work, doing what they could for the wounded. "The deck was so slick with blood and cluttered with bits of flesh and dead and mutilated men that it was difficult to move from one part of the ship to another. There is no need to describe all the pitiful cases. No one will ever forget! We had 15 dead and 30 wounded. Only four of the ship's crew were wounded. The other casualties were all from the beach battalion."

The ship made it out to the transport area, 10 miles from the beach, taking water slowly. After transferring the wounded to the USS *Samuel Chase*, Dr. Mike Etzil, Dr. John F. Kincaid, and Navy medical corpsmen who stayed to help with the casualties, climbed into a small boat. CDR Hendley reported that "they took their equipment and said nothing. They knew they were needed on

him to the beach. Moments later, Eugene M. Riggelman of the battalion swam 50 yards back out to sea under continuous enemy artillery fire against a strong tide to rescue a coxswain of an LCV (Landing Craft Vehicle and Personnel), which was disabled and sinking. "In spite of a direct hit on the craft while he was aboard, he brought the man safely ashore." The three amphibious sailors were awarded the Navy Cross.

Jerome Alberts in platoon A-3 of the battalion described the D-Day conditions over on Fox Red Omaha Beach. "Thousands of mangled bodies were strewn about, and hundreds of others were in agony awaiting evacuation. The task lay before us. Signal the Ships in! Stretcher bearers! Corpsmen! There was not an idle man. By noon, landing craft and Rhino ferries were taking them to hospital ships. I take my hat off to the medics, both Army and



Defense Visual Information Center

Both Army and Navy wounded of "Easy Red" Omaha Beach await evacuation. The 6th Naval Beach Battalion sailor with his face covered in bandages, John Gallagher, has just been treated by the author's father.

the beach. How many of them are living now I do not know." LCI(L)-85 went to the bottom of the Channel. The casualty rate of the battalion's medical personnel was 27 percent and less than a year after surviving "bloody Omaha," Dr. Kincaid was killed during a kamikaze attack off Okinawa.

Meanwhile, in the cold Channel surf off Fox Green, 6th NBB corpsmen James S. Brewer and Thurman W. Poe disembarked from an LCT (Landing Craft Tank) into deep water under heavy mortar fire. They were accompanied by a struggling Army captain. When the captain's life belt failed and he was in grave danger of drowning, Poe and Brewer went to the officer's rescue and brought

Navy. The work of Doctor Lee Parker of our platoon stands out in my mind. That man was everywhere and every place. One minute he was ten feet from me giving a man plasma, five minutes later he was aboard a beached LCT, treating scores of other wounded."

Because of the valor of Navy medical officers like Dr. Lee Parker, more than 99 percent of the injured assault troops evacuated by the beach battalions in Normandy survived the invasion. The mortality rate of the wounded reaching England was 3/10 of 1 percent. General Omar Bradley's First U.S. Army Report of Operations concluded that "Combined training with the Navy Medical Department is a must. Too much cannot be said about

the part which the Navy played in the early days of the landing operation.”

Official Army documents emphasize that during NEPTUNE, the amphibious assault phase of operation OVERLORD, the 6th NBB not only managed to accomplish their own mission, but “aided many other units in the accomplishment of theirs.” Under near catastrophic conditions on “bloody Omaha,” amphibious sailors of this naval battalion assumed combat roles in support of the assault, demolished beach obstacles, marked sea lanes, established shore-to-ship communications, directed the infantry landings, and provided medical aid and seaward evacuation for the many wounded and dying young Americans.

More than 55 years after D-Day, World War II veteran Jerry S. Stover, an Army officer who met with CDR Eugene Carusi on D+2 and witnessed firsthand the awesome job accomplished by the 6th NBB in France, made an inquiry regarding the Unit Citation recommendation. On 10 March 2000, the Department of the Navy announced that “research within Navy records fail to show that a recommendation was ever submitted or acted upon by the Navy Department for 6th Naval Beach Battalion.” Furthermore, the Army and Navy mutually agreed that a “unit history” would be presented to the Army Unit Awards Board since the 6th NBB was under the command of the Army 5th Engineer Special Brigade for operation OVERLORD.

It is interesting to note that despite intense inter-service rivalry during World War II, COL W.D. Bridges, one of the top Army commanders of D-Day, proposed a Unit Citation to honor an entire battalion of Navy amphibians. RADM Kirk, the highest ranking Navy commander of the invasion, provided theater endorsement. A grateful France awarded this battalion its War Cross, the Croix de Guerre with Palm.

For security reasons during the war, RADM John L. Hall, Commander of Amphibious Forces in Europe, did not want publicity for the Naval Beach Battalions in France. Over the past half century, authors of D-Day rarely mentioned their existence.

A recently published book providing an abundance of information and photographs regarding these unusual World War II amphibians is *Spearheading D-Day: American Special Units in Normandy* by Jonathan Gawne.

The October 1999 issue of *Naval History* reported that the Naval Beach Battalions in France play prominent roles in the opening battle scene of Steven Spielberg’s *Saving Private Ryan*. U.S. Navy Beachmaster Virgil Weathers, an 87-year-old beach battalion veteran said the

film was not exaggerated: “If anything, when they showed the bodies on the beach, they underplayed it.”

My father, a medical officer with the 6th NBB on D-Day, died more than 50 years ago, shortly after the war. As surviving veterans of the battalion are now entering the twilight of their lives, family members are grateful that the historical oversight of the unit citation was recently rectified. On 22 August 2000, through the Department of the Army and by the Commander in Chief of the United States, the 6th Naval Beach Battalion was awarded the Presidential Unit Citation for “extraordinary heroism” in military operations on Omaha Beach, Normandy, France, 6 June 1944. The veterans of this Naval battalion returned from World War II in silence and to this day, do not consider themselves heroes. Although Ed Marriott was one of the brave young sailors of 1944 who opened the invasion doors of France, he insists that “the real heroes of D-Day were the men we couldn’t save, the men we had to leave on the beach.”

The Normandy American Cemetery in France became the background for the opening and closing scenes of *Saving Private Ryan*. Every anniversary on the 6th of June, French school children place flowers on 9,286 American graves. The 5th Engineer Special Brigade Monument is located at the edge of the cemetery, directly above Easy Red. More than half a century ago, the U.S. Army inscribed on its own memorial the name of each 6th Naval Beach Battalion sailor who died on Omaha Beach. A large bronze plaque will soon be mounted on that granite monument with the following inscription: □

**THE OFFICERS AND MEN OF  
THE 6TH NAVAL BEACH BATTALION  
DEDICATE THIS PLAQUE TO OUR  
FALLEN COMRADES WHO GAVE  
THEIR LIVES IN  
DEFENSE OF GOOD OVER EVIL.  
THEY ARE THE SILENT SENTINELS  
WHO FROM THEIR FINAL RESTING  
PLACE ABOVE THE CLIFF  
PERPETUALLY WATCH OVER THE  
SACRED GROUND OF OMAHA BEACH.  
JUNE 6, 2001**

Mr. Davey’s father, LTJG J. Russell Davey, Jr., MC, USNR, was a medical officer with the 6th Naval Beach Battalion and landed on the Easy Red sector of Omaha Beach the morning of 6 June 1944.



# The Business of Research: Protecting Navy Medicine's Intellectual Property

In the Navy's biomedical and biotechnical research and development laboratories, it all begins with a scientist and an idea. A new way to solve a problem. To make the idea a reality, the scientist pulls together the needed resources and people, and many times that means building collaborative partnerships with US industries' subject area experts.

For the Navy these industrial partnerships are producing new ways to keep the fighting force fit and healthy. Current projects are focusing on products like palm-sized computers for hospital corpsmen to record treatment information in the field, small ID tags that hold complete medical records, a way to grow T cells in the laboratory, a new diagnostic tool to detect Dengue virus, an environmentally safe method to remove mercury from dental wastewater, a DNA malaria vaccine candidate, ingenious sound proofing material to protect helicopter crews from hearing loss, a software system to track emerging infectious diseases overseas, personal microwave and radio frequency detectors,

night vision goggle focusing aids, and the list goes on and on.

These collaborative efforts have commercial value to the business partners. They want to develop marketable products from the research results. The process of identifying the commercial value of the Navy's research findings and moving these findings to the private sector for further development and commercialization is called technology transfer. An important part of this process is safeguarding the taxpayers' investment, because Navy biomedical research is likely to deliver exceptional returns in the future. This requires identifying and protecting the Navy's intellectual property (knowledge, expertise, facilities, and inventions). The bridge between the Navy's medical research and development laboratories and private industry is the Office of Technology Transfer (OTT) at the Naval Medical Research Center (NMRC) in Silver Spring, MD.

Charles H. Harris, Intellectual Property Counsel at NMRC said, "Technology transfer goes on every time a researcher gives a presenta-

tion or submits a manuscript for publication. They don't need us for that part. Our role is to unlock the commercial value of the technology and extract some return for the laboratory, the Navy, and the taxpayer." He went on to add, "It is better to transfer the technology through formal cooperative research and development agreements or patent licensing agreements simultaneously with a researcher's professional distribution of the information."

OTT was created to accommodate the laboratories' growing demand for technology transfer services. OTT supports two major Navy research centers, NMRC and the Naval Health Research Center (NHRC), each with four subordinate laboratories or detachments.

OTT supports the researchers by designing partnership arrangements compatible with a laboratory's mission. Mr. Harris points out, "The primary focus of military medical research is to protect the Sailor, Marine, Soldier, and Airman, no matter how few get injured or how uncommon the disease. The military member is of

critical importance to us. Our researchers go the extra mile for them to protect their health. The primary motive of business is to make a profit; the larger the market they have the larger the profit they make. For example, if the results of military research leads to a new drug that has a civilian use and appeals to a much larger patient population, that could be profitable for a pharmaceutical firm, and that's to the taxpayers' advantage. The technologies our researchers develop are defense related, and much of their work is not valuable in terms of technology transfer and commercial development. What we look for is dual use--a military aspect and a commercial aspect."

The two most common methods of technology transfer are negotiating formal Cooperative Research and Development Agreements (CRADAs) and licensing Navy-owned patents. CRADAs establish the legal framework and describe the research relationship and specific details including expected outcomes, shared resources, and intellectual property rights. CRADAs outline the business partner's contributions to the Navy's research efforts and can include funds, personnel, and equipment. CRADAs do not allow the Navy to contribute funds, but do allow the Navy to provide personnel, facilities, and equipment to the cooperative effort. Because of these formal arrangements Navy scientists can work closely with their private sector counterparts, exchanging ideas and information and at the same time protecting the partner's opportunity for commercial development. This is possible because the intellectual property rights are settled prior to beginning the research, nondisclosure terms are legally binding, publication provisions are detailed, and the research findings

and related documents are exempt from Freedom of Information Act requests. CRADAs also allow flexibility in patent processing and patent licensing arrangements, allowing the Navy and the industry partners to share patent and patent licenses, or permitting one to retain exclusive

rights. The number of Navy biomedical CRADAs has increased each year because all partners are able to share benefits and resources effectively and equitably.

CDR Charles J. Schlagel, MSC, the OTT Marketing Director, highlights the success of the OTT staff, "We



The Technology Transfer Team (l to r) includes Charles H. Harris, Intellectual Property Counsel, CDR Charles Schlagel, MSC, Marketing Director, and Mr. Ken Hemby, Patent Advisor. They join Ms. Diana Jane Hall, a civilian laboratory technician in the Biological Defense Research facilities at the Naval Medical Research Center.



currently have 108 active CRADAs, up from 50 just 2 years ago. Private industry isn't interested in yesterday's technology. They are willing to commit their resource to the Navy's biomedical research efforts because the cooperative work will enhance their competitive edge. Industry comes to us seeking cooperative agreements and wanting to license our technology. This is a strong endorsement that our scientists are on the cutting edge. If they weren't, industry wouldn't be beating a path to our door!"

A variety of licensing options protect the Navy's interest in the commercial use of laboratory-developed technology. A major role of OTT is negotiating royalty-bearing licenses and payment of patent expenses. Currently OTT has 48 active patents and 50 patents pending, with several new patents being drafted. A percentage of the royalty income is paid directly to the researcher(s) named on the patent and the remainder is distributed to the laboratory to be used for further research, monetary awards for support personnel, and education and training programs.

CDR Schlagel said, "Frequently our scientists don't appreciate the commercial value of the research they are doing, they are so focused on the military mission. We encourage them to think of broader uses or new applications. For example, we might have a treatment to restore the hematopoietic system of a Sailor or Marine who has suffered extensive burns or who has been exposed to radiation or chemical/biological agents. This treatment would have great clinical applications for civilian medicine and would be of critical importance to public health. Through technology transfer we can work with industry to further develop and commercialize the treatment."

The growing number of CRADAs and patents are reflective of the OTT success story for two reasons. First, the primary mission of the laboratories is to keep the warfighter fit and healthy and research results are directed toward military-unique uses. Second, in the area of biomedical therapeutics, vaccines, medical devices, equipment, and research tools it takes a very long time for the technologies to get to the market place.

Ken Hemby, OTT Patent Advisor, points out "Considering the FDA approval costs, it can take 10 years or more and upwards of \$100 million to get a new drug to market. If our scientist can successfully demonstrate a basic technology and we hold the patent, we can transfer that technology to industry and provide an incentive for them to commercialize." He went on to explain that granting an exclusive license of a Navy-owned patent to an industry client provides the incentive. This type of license excludes others from making, using, or selling the technology. Without such an incentive, technology transfer would clearly not be as successful, because an industrial client would likely not make the needed investment.

The future of technology transfer is fluid and depends on the evolving technologies and the demands of the marketplace. Typically a CRADA spans a period of 2 to 5 years. For patents, pre-GATT (General Agreement on Tariffs and Trade) terms are 17 years from the date the patent was issued and post-GATT is 20 years beginning when the patent application was first submitted. On 8 December 1994, Congress amended US law to conform to the GATT and revised key portions of US patent law.

Using their collective technical, legal, business, and marketing expertise,

the OTT staff conducts a series of assessments beginning with a technical review that includes identifying emerging technologies still at the bench. This is followed with a legal review to protect the intellectual property and to formalize licensing agreements between the Navy and industrial clients. OTT staff members work closely with potential partners who are required to present a detailed business plan focused on a specific Navy technology. This includes evaluating similar technologies, determining cost and pricing information, and estimating market size and trends.

Mr. Harris said, "This office is a corporate asset in terms of general counsel and technology transfer to the Navy's biomedical and biotechnical research system. We serve several laboratories with different missions and different cultures. We are finding that the number of patents are increasing and we have to be able to handle that. Requests for collaborative arrangements are also increasing. We have to be prepared to help our scientists formalize these arrangements. These research relationships are becoming more complex as the technology becomes more complex and the commercial appeal to industry is growing."

For more information on the Office of Technology Transfer or to review the patents available for licensing contact the Office of Technology Transfer at:

[harrisc@nmrc.navy.mil](mailto:harrisc@nmrc.navy.mil) or visit the OTT section of the NMRC web site at <http://www.nmri.nmrc.navy.mil>.

—Story by Doris M. Ryan, Medical Research and Development Division (MED-26), Bureau of Medicine and Surgery, Washington, DC.

# Frozen in Memory

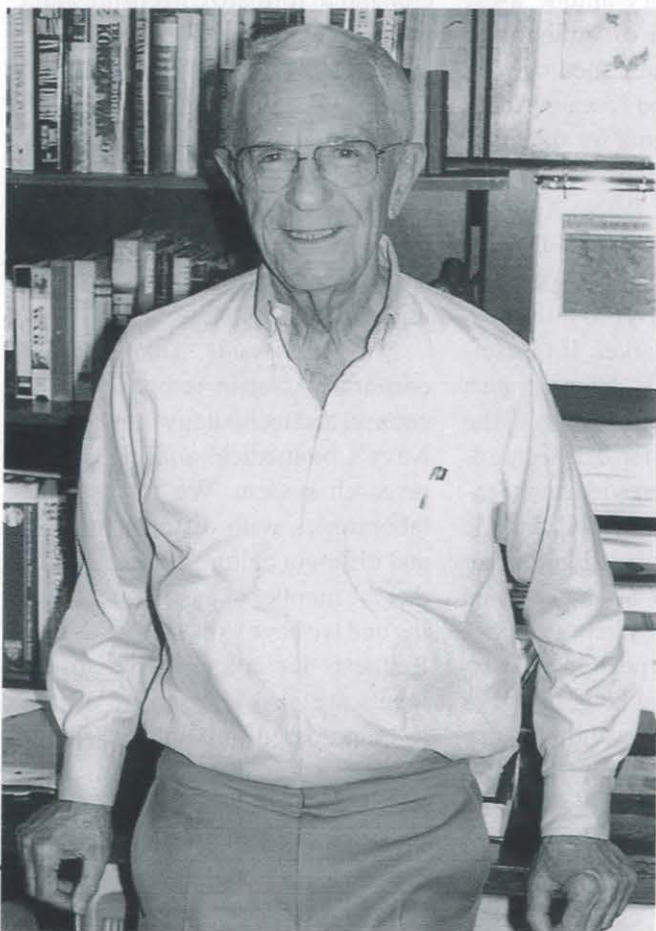


Photo by the Editor

Dr. Litvin

**B**y late September 1950, GEN Douglas MacArthur's brilliantly planned and executed landing at Inchon and the quick recapture of Seoul had dramatically changed the complexion of the Korean War. U.N. troops, once faced with annihilation by the North Koreans, were on the offensive all across South Korea chasing the fleeing enemy back across the 38th Parallel.

It was then that President Truman and his advisors made the fateful decision not only to punish the aggressors who had started the war, but liberate the communist north, thereby insuring the reunification of the two Koreas.

## Recalling Chosin Reservoir

Henry Litvin, M.D.

*The coup de grace was to be another landing, this time on North Korea's east coast. Extreme tides had bedeviled the Inchon planners. At Wonsan, the problem was a heavily mined harbor that delayed the landing for 2 weeks. While mine-clearing proceeded, men of the 2nd Battalion, 5th Marines and other units aimlessly cruised up and down the Korean coast aboard crowded LST's and other vessels in what the men derisively called "Operation Yo-Yo." LTJG Henry Litvin, MC, now a "veteran" of Inchon, Kimpo Airport, and Seoul, shared the bad food, seasickness, gastro-enteritis, endless card games, and boredom.*

*When the Marines finally disembarked at Wonsan, the port had already been captured by ROK (Republic of Korea) and U.N. troops. Greeting them was a sign reading "Bob Hope welcomes you." What they could not know was that within a few short weeks, the war in Korea would again change dramatically. As they worked their way north, ever closer to the Manchurian border, Marines, whose traditional role was conducting operations from and near the sea, encountered rugged mountain terrain, a brutal winter climate, and finally thousands of quilt-uniformed Chinese who suddenly descended upon them in hordes. There are places and events now frozen in the memories of the campaign's survivors—Chosin Reservoir, Yudam-ni, Toktong Pass, Hagaru-ri, Koto-ri. Dr. Litvin, one of the "Chosin Few," recalls how he cared for the sick and wounded, and survived an unmerciful environment where it always seemed the very next moment would be his last. - Ed.*



Marines of the 2nd Battalion, 5th Marines set up a command post in the hills around Chosin Reservoir.



Defense Visual Information Center

From mid-October to early November, we slowly worked our way up east of the [Chosin] Reservoir. Patrols that went out brought in Chinese prisoners every once in a while. And then suddenly the weather turned cold. I was having breakfast one morning, gulping down some eggs. When I went to get the coffee, it was frozen. I couldn't imagine coffee freezing. We didn't have a thermometer but it had to have been well below zero. It occurred to me right then that practicing medicine was going to be a difficult thing.

I attended a meeting of Marine officers somewhere up on the way to Hagaru-ri, where they talked about the move we were going to make north. Many things were discussed but the thing that stuck in my mind was a high-ranking Marine officer's comments about frostbite. I vividly remember him talking about it the same way he'd view a sunburn, namely something that could be avoided. So when I first heard about frostbite I figured these guys were going to get into trouble. But frostbite couldn't be avoided when you were pinned down, had sweaty feet, and couldn't change your socks. If you were wounded and lying there, you couldn't change your socks. If you were wounded and strapped to a vehicle, your sweat froze. In hindsight, it's a miracle that anybody avoided frostbite. It didn't resemble trench foot like they had in World War I, when feet were cold and wet for long periods of time. We were wearing shoe pacs which were rubberized boots. If you walked 20 feet in them your feet started to perspire. And if you stopped, they'd freeze. I was in a position where I could maybe change my socks once a day. But there were a lot of troops who could not change their

socks if they were pinned down or fighting. Changing your socks at 20 below with a stiff breeze is murder, but they did it. We'd go up and down the line telling people to stamp their feet, change their socks, and keep moving.

As for clothing, everybody had long johns, two layers of trousers, those flannel shirts, maybe a field jacket. Everybody had a parka and gloves. When we tried to deal with the wounded we'd take our gloves off and our fingers would freeze.

Water was also a problem in that intense cold. Everybody was dehydrated. I had never experienced such an overwhelming thirst. You read about the exhaustion and the cold but you never read about the dehydration. There was nowhere to get a drink. Up in those mountains the humidity is low. We were losing a lot of moisture from our skin. Once I grabbed a canteen and found myself trying to suck ice; the contents were frozen solid. There were water trucks down south but I never saw them up north. We had to melt snow to make coffee. For days, we went without any food. We were starved but not hungry. At one point someone found a cache of Tootsie Rolls so we loaded up on Tootsie Rolls.

Everybody had runny noses. It ran into their moustaches and froze. Everybody was filthy, grimy, dirty, and crawling with lice. And can you imagine having to move your bowels. The wind's blowing 20 or 30 miles an hour and it's 40 below zero and you have to go. You do what you have to do and you don't have time to wipe. Peeing was easy.

If you were treating a wound, you'd cut through the clothing to where the wound was or you'd put a battle



Marines collect their wounded and dead after fighting off three Chinese divisions at Yudam-ni.

dressing over the clothes and make sure the wound wasn't leaking blood. I remember vividly one Marine after Yudam-ni. When he approached the tent it looked like he had a block of pink cotton candy sitting on his shoulder. I couldn't imagine what I was looking at. As he got closer, I noticed it was pink, frothy ice. I broke it off and then realized he had been hit and had a bleeder above his ear. Frozen blood is frothy pink. It was actively bleeding and freezing, bleeding and freezing.

It seemed that the intense cold inhibited bleeding. The wounds we saw had already been wrapped by corpsmen in the companies. If the battle dressing was in place, even over their clothing, and there was no leaking blood, we just checked the battle dressing and left the wounds alone.

I saw head wounds and leg wounds. There were some belly wounds. There were countless extremity wounds that blur in my mind. There was one guy with a sucking chest wound, and I remember getting an idea. I said, "Does anybody have a rubber?" Then thinking, "Who would have condoms up here?" One guy had one. I unrolled it, taped it over the wound, and cut some little slits in it thinking that if he developed a pressure pneumothorax, the air would get out. I was able to get this kid out on a helicopter.

Remember, the helicopters then were not like the ones they had in Vietnam. They had a bubble for the pilot and, if you had a guy on a litter, half of him stuck out. He was the only one I got out by helicopter. We saw helicopters that looked like the wind had dashed them against the sides of the mountains. They looked like broken little toys. There weren't a lot of helicopters flying.

The Chinese attacked at night or when it snowed, for the most part, often announcing their presence with whistles and bugles. But the thing I remember most were the mortar explosions. All night long you heard them. And all those explosions didn't do much to improve my hearing. I had tinnitus then, which I didn't pay much attention to but I'm sure my deafness today is related to that. After seeing all the bullet holes in the tent canvas, you wanted to go outside and stretch and look around. In the morning, I remember seeing hundreds of unexploded Chinese mortar shells on the ground.

We worked at night because that's when most of the wounded were coming in. We had no table. Most of the time we were on our knees or bent over somebody on the ground or on a litter doing some procedure.

I never saw a pair of sterile gloves in Korea. I never saw forceps or anything sterile in Korea. The only things sterile were the battle dressings and the morphine syrettes.

We never knew how long it was going to be until the wounded person could get to further care. So we protected them by using sulfa. I think it was more for ourselves. We were doing something. At the time you didn't think too much about it. You just did it. We never had IV fluids at any time at our battalion level. They would have frozen solid.

Down south when you treated the wounded, you checked for bleeding, splinted them, gave them something for pain, and evacuated them. Up north you did the same things but you had to hold onto your patients because there was no way to get them out and the numbers kept growing. Soon we were getting hundreds of casualties yet there



was no place to put them. When we had wounded and no place to send them, we'd push them to the side or get them into another tent, if there was one—and usually there wasn't—or out in the open covered with a tarp. Or we'd put them in a truck and stack them like cordwood. We stacked them the way the dead were stacked. We tied them on the hoods of jeeps or trucks. There was no regiment to send them back to. We were the end of the line—the rear guard. If they could walk, they walked.

I remember a lieutenant. He looked like a very young kid—blonde hair. They brought him in and put him down. There was a bullet hole in the side of his helmet. He was lying on the snow and breathing but not conscious. I removed his helmet and his brains spilled out like oatmeal onto the snow. He was still breathing and had a pulse. The bullet had entered and ricocheted around the inside of his helmet and just . . . I remember putting the helmet back and saying, "Move him out there." These are memories that stay in your head forever.

We went days and nights without rest. We were exhausted. There were few times when you could get horizontal because it was at night when the casualties were coming. During the day you were moving so you went days with no real sleep. When we stacked the wounded on trucks, you thought, "Thank God, at least they are getting to lie down." But I'm sure many wounded froze. The fact that I kept walking, like most of the guys at the aid station, helped me avoid freezing. If you stopped and sat, you'd freeze. I can't prove that many of the wounded froze, but I suspect that's what must have happened.

I don't know what we would have done without the corpsmen. There were corpsmen who had been seasoned in World War II and there were corpsmen as green as I was. They didn't have to fight with rifles but they went to where they were called. They were always on the go. I wasn't up with the companies to see them, but at the rate at which they were getting hit, these guys were unsung heroes. When the call went out for corpsmen, they went.

One memory stands out. It was November 27th about 10 pm. There had been some firing during the day and we had stopped for the night. Seven or eight of us were sitting around in a tent. There was a lantern going. It was cold and the wind was blowing. Suddenly this guy slides down the hill right through the side of our tent with no shoe pacs on, no helmet. He says, "Where's the colonel? Where's the colonel? I need to tell him. They've overrun us! Fox Company has been overrun." It seems the Chinese were atop the hill just above us.

With that, all of us flew out of the tent, door or no door, right through the sides. I rolled down across a little road, down a gully towards a frozen little creek. It was dark but I hid behind a bunch of bushes and lay there shaking. The attack had started and there was a racket—whistles, bugles, rockets, explosions, and firing. People were shouting. "What do I do?" I thought. I couldn't see what was going on. I asked myself, "What am I supposed to do?" I lay there with another guy. I never knew who he was.

After a while we heard, "Corpsman! Corpsman!" With that, all of us moved back to the aid station and began to treat wounded. No matter how scared I was, and believe

The only way out: casualties from the Chosin Reservoir campaign are loaded aboard a C-47 at Hagaru-ri, November 1950.



BUMED Archives



Leathernecks pass destroyed and abandoned equipment during their breakout from Chosin.

me, I was scared, when you did your job you weren't helpless. Perhaps the sprinkling of sulfa into their wounds was more for me than it was for the patient. In a bombardment when you were doing nothing but waiting for a shell to drop, you were completely helpless and that was traumatic as hell and the most devastating thing in the world. There were days on the way back when we'd look up towards dawn and see light shining everywhere through the canvas and realize that the tent was full of bullet holes. But I understood that as long as I was doing something, I didn't sit there like a shaking lump of jelly. Work was a great thing for the doc—it overcame his terror.

On the 28th [November] we began moving back to Yudam-ni and came under fire. I remember there was nowhere to hide. Mortar rounds and fire were coming in. We had seen Chinese coming over the mountains and my feeling was, "Let's get the hell out of here. Let's keep going *that* way."

We didn't move a quarter of a mile before we saw Chinese pouring over the hill we just left. They were all around us. We felt they were going to overrun us then or in the next hour. I felt like I was literally waiting to die.

For days we were moving down from Yudam-ni to Hagaru and the Marines were fighting like hell. I don't know how many days we walked. I never rode. I always

walked. But I noticed that as we got closer to Hagaru, everybody began changing the way they walked. When we entered Hagaru, we were marching like military men.

At Hagaru all our wounded were turned over to Regiment. There was an airstrip so they were able to fly them out. When they had an air drop you had to run to get out of the way because when those things came down—food and military supplies—they'd flatten tents and go right through huts. But it was exciting. It made you feel good. They hadn't forgotten us.

On December 6th, troops had been filing out of Hagaru all day on the way to Koto-ri. By nightfall, there were few troops left to defend our position from the same number of Chinese we had been fighting for 3 days. That's when they brought in CAPT Uel Peters [Commanding Officer, Fox Company] sitting on a litter holding a tourniquet. His leg was out like that, a compound fracture, displaced, and his flesh was glowing. We were in a tent with a Coleman lantern which didn't provide great light. But when they brought him in we could see his leg glowing. "What the hell's that?" I asked. One of my corpsman told me it was white phosphorus. I thought, "What the hell do you do with white phosphorus?" He gave me a solution, told me it was copper sulfate, and told me to dab it on the wound. I remember dabbing it for hours until all the glow went away. That corpsman knew about white



phosphorus from the South Pacific battles of World War II.

Peters had flesh and bone exposed but his wound was not actively bleeding. In fact, I don't remember seeing any active arterial bleeding while I was up there but for that guy who had the block of ice on his shoulder. Peters subsequently lost that leg. The thought has many times gone through my head, "Could I have done something different?" But I guess I did the best I could. These kinds of thoughts stay with you.

Our aid station was frequently surrounded by unexploded mortars. About half a city block away, East Hill began to rise. It reminds me of that Prudential ad with the Rock of Gibraltar. There were a lot of hills but it stuck out. It was a big, ominous, dark, forbidding presence. To me it has to be symbolic because that's where many of our troops were dying.

That same day—the 6th—everybody was funneling out of that valley blowing up supplies we didn't want to leave for the enemy. We were headed for a place called Koto-ri. Well, we were the last ones left that night. I was thinking, "We're dead!" All the troops who had been fighting off the Chinese had gone and we were still there. And we had the same enemy to deal with. That was a night! That was the night they brought in Karle Seydel. Karle Seydel was the guy who took me under his wing on the ship before Inchon and had shown me the ropes. He had taught me how to put my pack on . . . He was a Marine's Marine and yet he stood on the railing of that ship going to Inchon reciting poetry. He was important to me because he reached out to me. "Don't worry, Doc. You're with amtracs and you're not with the infantry. You'll be all right." They brought Karle in and he had a bullet in his forehead. I remember . . . so many dead, so many wounded. But this guy I knew better than I knew anybody. I spent more time with him. It seemed so terrible. I wanted to do something, but his face was gray and he was dead. Every Memorial Day after that I'd reminisce, and Karle Seydel's name would come up. I'd remember him there at Hagaru. He wasn't the first dead Marine I saw but he was a very important Marine. I have a hard time with his death to this day.

Many times I had the feeling of utter hopelessness. There's no way to get out of here. We're too far away from the sea. We're 70 miles up in the mountains and they've got us surrounded. And they could have destroyed us but they didn't. Maybe the Chinese knew they were up against Marines who knew a thing or two about how to fight.

Another thing amazes me. To have walked the distance we did out of there is mind-boggling until you consider the Marines who ran up and down the hills covering us. It's one thing to make the hike but how about the guys who were running up and down tangling with the enemy on top of those ridges.

There is one view I have where we came around the bend of a road and all of a sudden I could see a plain in the distance. There were no longer peaks and valleys. It was a broad plain. We were at the bottom of a mountain range and prepared to head down towards the sea. They put us on trains—flat cars—wood-burning trains—and took us the last 10 or 20 miles. It was at night. You were sitting on a flat car with one Marine right up against you and another right behind. We were numb with exhaustion. A shower of sparks from the locomotive was falling on us, and I remember watching the sparks burning holes in my parka—pretty, orange holes burning in my parka.

We got to Hungnam and showers and food. I don't have a memory of seeing the ships until we were getting ready to board them. Being pulled aboard those ships, I remember thinking, "The Navy didn't abandon me. The Navy didn't forget about me." When I got to the top of the ladder, a couple of sailors grabbed me and I went sliding across the deck as happy as a lark. The first time I walked into a bathroom and started peeling my clothes off I looked at myself. Skin and bones . . . and this beard. I had lost 33 pounds.

I'm not equipped to evaluate warriors but, from what I saw, those Marines were superb. I never saw a Marine officer or enlisted man who looked scared. That doesn't mean they weren't. Everybody was doing what they had to do. I never saw anybody smile and never heard any joking or clowning up there. But the Marines fought and fought well, and maintained discipline. They took care of the aid station and protected it. They supplied the vehicles when I needed them. They looked out for their wounded. They brought all their wounded back.

There are few things in my life that I can feel as proud of as my service to this country in Korea with the Second Battalion, 5th Marines. I didn't like it one damn bit. I was there and luckily I survived. The Navy needed doctors and I happened to be one of them. I've been prouder of that than anything I've ever done.

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Dr. Litvin practices geriatric psychiatry at Abington Memorial Hospital, Abington, PA.

# Achieving Wellness

LCDR Josephine Brumit, NC, USN

**T**here is a definite shift in Navy medicine from illness treatment to prevention and wellness. Achieving and maintaining wellness improves military readiness, enhances quality of life for both Sailors and their families, and reduces health care costs. Proactive health promotion programming is increasingly evident throughout the Navy both at sea and on shore. NACC Groton, CT, has established a comprehensive wellness program that is successfully collaborating with line commands to accomplish health promotion initiatives. Wellness programs are intended to improve both the health of individuals and of the population as a whole. The purpose of this article is to provide an overview of the program including lessons learned which may be of interest to other commands establishing health promotion programs.

NACC Groton's Wellness Support Department was created in November 1997. Built from the ground up, it consists of a multi-disciplinary team of health care professionals including a social worker, nutritionist, public health nurse, patient educator (registered nurse), corpsman, and secretary led by a community health nurse. The fact that the team is multi-disciplinary is one of its greatest strengths since effective health promotion programming requires expertise from all of these professions.

The timing of the department was opportune since the facility was

transitioning from a hospital to an ambulatory care center, necessitating dramatic role changes, particularly for the social worker, nutritionist, and patient educator. Assimilating these existing inpatient-focused roles into a wellness team and adding the new positions of public health educator and community health nurse optimized available resources and successfully refocused patient care in the new outpatient, ambulatory care environment. In addition to the dramatic shift from inpatient to outpatient facility, the implementation of managed care in the form of Tricare also changed health care practice at the facility. A third factor was the transition of the MTF at Groton from an independent command to part of a regional command, Naval Health Care New England (NHCNE) consisting of NACC Groton, CT, NACC Newport, RI, NACC Portsmouth, NH, and Branch Medical Clinics Ballston Spa, NY, Brunswick, ME, Cutler, ME, and Winter Harbor, ME. Each of these factors individually would have been challenging, the combination of all three occurring simultaneously was particularly demanding.

The first step in creating a health promotion department was rewriting position descriptions for existing positions to incorporate wellness responsibilities and writing position descriptions for the new positions. For example, the social worker became a case manager since the establishment

of a case management program is necessary to assist patients with multiple chronic illnesses or catastrophic illnesses in attaining and maintaining wellness and is also required by the Tricare contract. The nutritionist role shifted from the provision of inpatient dietary counseling to health promotion education in weight control and general nutrition to assist patients with improving their lifestyle behaviors associated with nutrition. The patient educator role changed from largely discharge teaching to changing lifestyle behaviors to improve health, particularly focusing on tobacco cessation and breast cancer initiative programming. The public health educator role includes assertive marketing of programs and the conduction of community surveys. Every member of the staff provides general military training (GMT) and community outreach education in the medical clinics and in the community through community health fairs and other wellness events.

The second step in creating a health promotion department was conducting a community assessment to identify existing community resources for health promotion and to identify wellness opportunities in the NACC Groton beneficiary community. Health promotion is an important component of community health and the conduction of annual community assessments is an essential benchmark in civilian community health practice. The identification of community resources and



health care needs is essential to the establishment of a comprehensive, accessible, and effective health promotion program.

In developing the NACC Groton health promotion/wellness program design, research was conducted to determine Navy health promotion objectives. Both Department of Defense and Department of Navy instructions mandate the inclusion of seven essential components in health promotion programming. These are: (1) physical fitness, (2) weight control, (3) tobacco cessation, (4) stress reduction, (5) blood pressure screening and education, (6) alcohol and substance abuse education, and (7) back injury prevention. Suicide prevention is an element added to many programs. An additional element, prenatal wellness, was identified through community assessment for the NACC Groton beneficiary population. Obstetric care is contracted out to local civilian facilities and it was determined that many pregnant women were not receiving prenatal care until near the end of their first trimester. The first trimester is the golden window of opportunity in terms of prenatal wellness. It was therefore imperative to accomplish health promotion education early in pregnancy to optimize both maternal and newborn wellness. One mechanism of accomplishing this was the development of a prenatal screening tool that was implemented in the clinics including the military medicine clinic for use in determining prenatal education and resource utilization needs. Another was the implementation of twice yearly prenatal health fairs involving several commands on base that provide services to pregnant women and newborns. These prenatal health fairs have been extremely successful.

The third step, which was essential to success, was the establishment

of a base-wide Wellness Council with both line and medical representation to plan and implement health promotion events in the community and at the deckplates. It was the first base-wide wellness council at Naval Submarine Base New London, CT. Effective collaboration across commands optimizes program effectiveness and resource utilization (both personnel and material) and allows for the coordination and streamlining of related services.

The training of wellness staff in health promotion was required to prepare them for wellness responsibilities, particularly when incorporating existing positions into the health promotion team that did not previously include wellness duties. The Navy Environmental Health Center (NEHC) has been an invaluable resource. Two particularly important training programs offered by NEHC are the Cooper Course which prepares individuals to be health promotion officers/health promotion program coordinators and Health Promotion at the Deckplates which provides attendees with pre-packaged lesson training guides in all seven mandated health promotion program elements.

Lessons learned include the importance of effective networking and assertive marketing. Establishing a network of resources, both line and medical, is essential and the establishment of a base-wide wellness council goes a long way in the accomplishment of this goal. The importance of marketing cannot be overemphasized. All available marketing tools such as command newsletters, ombudsmen newsletters, local military, and civilian newspapers and Navy Family Service Center public television programming should be utilized. The American Red Cross may be able to provide assistance in the preparation of wellness classes and events using volunteers

who are registered nurses. The active involvement of every member of the base-wide wellness council is essential. Thorough community assessments can identify opportunities to increase access or identify education needs unique to the community being served that may not otherwise be determined. It is cost-effective to base programming on community needs identified through objective assessment. Effective outreach is required to expand access to health promotion programming. For example, at NACC Groton, the Wellness Support Department is not physically located within the clinics. Having staff members provide outreach services in the primary care clinic spaces on a routine schedule has expanded access. Most importantly, obtaining support for health promotion programming from the chain of command is vital to success. Briefings to senior leadership on the advantages of health promotion can accomplish this.

The bottom line is that achieving wellness, both at the individual and community levels, requires people to adopt healthier lifestyle behaviors. Effective health promotion programming empowers people to do this. Both military readiness and quality of life can be markedly improved through the attainment and maintenance of wellness. The time to build comprehensive wellness programs across the Navy is now.

The contributions of the entire NACC Groton, CT, Wellness Support team have been invaluable to the success of the program. □

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LCDR Brumit is Assistant for Women's Health Issues (MED-02W), Bureau of Medicine and Surgery.

## IN MEMORIAM

**CAPT Emanuel Navarro Buckley, MSC (Ret.)**, died on 21 July 2000 at his home in San Diego. He was 77.

Born in Nicaragua, CAPT Buckley and his parents moved to San Diego in 1928. He graduated from San Diego High School in 1940 and earned a bachelor of science degree from Southern Illinois University.

CAPT Buckley joined the Navy in 1941, receiving boot camp training in San Diego, as well as training to be a hospital corpsman and clinical laboratory technician. During his enlisted service he was promoted to every enlisted pay grade. In 1952 he was appointed an ensign in the Medical Service Corps and retired as a captain.

During World War II, while serving on the USS *Rixey* (APH-3), he participated in the liberation of Guam and the Philippines, and the invasion of Okinawa. He served on the USS *Shangri-La* (CVA-38) from 1956-58. CAPT Buckley served during the Korean and Vietnam Wars. In Vietnam, he was assigned as the hospital administrator aboard the hospital ship USS *Repose* (AH-16). In all, he was on active duty for over 42 years, retiring in 1983 while assigned as executive assistant to the Surgeon General of the Navy at the Bureau of Medicine and Surgery.

CAPT Buckley held the Legion of Merit, the Meritorious Service Medal, and several theater service medals and engagement stars.



## CORRECTION

In the Sep-Oct 2000 issue of NAVY MEDICINE on page 21 — VADM Bulkeley's date of death is listed as 1999, the correct year of death is 1996. The christening date of the USS John D. Bulkeley was listed as 24 January, the actual date was 24 June.

## NAVY MEDICINE AT WAR VIDEO SERIES CONTINUES



On 26 July 00, at the Bethesda, MD, Headquarters of AMSUS, Executive Director RADM Frederic Sanford, MC, USN (Ret.), presented a \$5,000 check to Mr. Jan K. Herman, Historian of the Navy Medical Department.

This grant will help produce the second video in a 7-part series, which will document the history of Navy medicine in World War II.

The series is based on oral interviews with Medical Department veterans — physicians, dentists, nurses, and hospital corpsmen who saw the war from their own unique perspectives.

The current video depicts the participation of Navy medicine in the invasion of Normandy on D-Day, 6 June 1944. Without the support of organizations like AMSUS, this very important documentary series would not be possible.



## Book Review

***The Dragon's Breath: Hurricane at Sea* by CDR Robert A. Dawes, Jr., USN (Ret). Naval Institute Press. Annapolis, MD. 222 pages, 1996**

The USS *Warrington* (DD-383) capsized and sank 300 miles off the Florida coast on 13 September 1944, the victim of a vicious hurricane. Three-fourths of her crew were claimed by the sea after heroic efforts to save the ship. CDR Robert Dawes was the commanding officer of the *Warrington* prior to relieving her to CDR Samuel Quarles who commanded her during her final voyage. Many of the survivors were able to piece together the events of what happened to the destroyer and this book describes not only what happened but recounts the subsequent court of inquiry that followed. The author does not have kind words for the court of inquiry which treated survivors harshly and failed to recognize fully the heroism of the crew which fought the overwhelming storm.

What does such a book mean to the men and women of Navy medicine? One of those heroes who perished and has been forgotten by everyone except those who served on that frightful September day was LTJG Robert M. Kennedy, MC, who paid the ultimate price upholding the highest ideals of the Hippocratic Oath. Chief Radioman Arthur B. Tolman was washed overboard and back aboard the destroyer trying to reach the emergency radio shack and sustained multiple injuries. Only minutes before the destroyer capsized, per-

mission to abandon ship was given and sailors scrambled aboard life rafts. Radioman Second Class Paul Kligen went into sick bay to inform the doctor to abandon ship. Both tried to assist Chief Tolman out of sick bay but he was in too much pain. Dr. Kennedy then announced that he would stay with his patient. Both then perished in seas that showed no mercy.

The author believes the court of inquiry went out of its way to emphasize that Dr. Kennedy was unaware the ship was being abandoned. He also argues that the Medical Corps officer never received the recognition he deserved for the heroic act of staying with his patient. Dawes is extremely thorough in his research of the events that led to the sinking of the *Warrington* and mentions LTJG Kennedy several times.

This review is written in tribute to those who gave their lives for their shipmates and to highlight the heroic physician's actions. I urge my fellow colleagues of Navy medicine to memorialize LTJG Kennedy by naming a new branch clinic, medical wing, Navy medicine program, or scholarship after him. The author said it best: The court of inquiry failed to recognize LTJG Robert M. Kennedy, Medical Corps who acted in the highest traditions not only of the Navy, but the medical profession as well.

—LT Youssef H. Aboul-Enein, MSC, USN, is Plans, Operations and Medical Intelligence Officer, Naval Hospital, Great Lakes, IL.

## NEWS RELEASE

The Society of Civil War Surgeons, the largest organization of its kind dedicated to the study of Civil War surgery and medicine, will hold its 8th National Convention on March 16-18, 2001 at the Radisson Read House Hotel, in Chattanooga, TN. The convention fee includes all lectures on Friday and Saturday, the pre-conference workshop on Friday morning, Friday night hospitality reception, dinner with musical entertainment Saturday evening, two breaks on Friday and Saturday, and a tour of selected Civil War sites in the Chattanooga/Chickamauga area, including some medically related areas. Leading authorities in the field will speak on various topics and will be the mainstay of the convention. Our after-dinner keynote speaker is tentatively scheduled to be the U.S. Army Surgeon General. Other speakers include, but are not limited to, Debra Chisolm Reuhlman, the great, great, granddaughter of Dr. J. Julian Chisolm, CSA, Jack D. Welsh, M.D., T. Adrian Wheat, M.D., and Bruce Evans, M.D., all noted authors and historians in Civil War medicine. We are offering special student rates, with appropriate school ID, for 1-day attendance.

For information on The Society and/or registration packet contact: Peter J. D'Onofrio, Ph.D., President; Society of Civil War Surgeons, 539 Bristol Drive, S.W., Reynoldsburg, OH 43068. E-mail us at: [PjdSOCWS@aol.com](mailto:PjdSOCWS@aol.com) or visit our website at: [www.civilwarsurgeons.org](http://www.civilwarsurgeons.org)

# Index

Vol. 91, Nos. 1-6, January-December 2000

- ABOUL-Enein, Y.H., LT, MSC  
book reviews  
*Dragon's Breath: Hurricane at Sea* 6-25  
*MASH: An Army Surgeon in Korea* 4-28  
*Mission of an American Military Doctor in Occupied Japan and Wartorn Korea* 3-27  
*To Bind Up the Wounds: Catholic Sister Nurses in the U.S. Civil War* 5-28  
*War and the Red Cross: The Unspoken Mission* 2-28  
*We Band of Angels* 1-28  
What will replace hospital ships? 1-9  
Achieving Wellness 6-12  
Adams, C.E., CAPT, MC, new medical department flag selections 5-6  
Arjoso, S., developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1  
Armed Forces Institute of Pathology collaborates to improve body armor 2-5
- BANULL, C.M., LT, MC, USNR, high altitude medicine: case report 1-24  
Benavidez, M., HM3, Cherry Point medical personnel recognized for hurricane Floyd support 1-1  
Blighton, G.R., LTJG, MSC, Cherry Point medical personnel recognized for hurricane Floyd support 1-1  
Blue Angels, Navy medical team helps keep Blue Angels flying 6-1  
Blue Angels Chemistry and 'Cresting' give Corpsmen yellow-gear mentality, and C/MC reason to brag 6-1  
Bohnker, B.K., CAPT, MC, Cherry Point medical personnel recognized for hurricane Floyd support 1-1  
Book reviews  
*Dragon's Breath: Hurricane at Sea* 6-25  
*History of the U.S. Army Nurse Corps (Studies in Health, Illness, and Caregiving)* 3-28  
*MASH: An Army Surgeon in Korea* 4-28  
*Mission of an American Military Doctor in Occupied Japan and Wartorn Korea* 3-27  
*To Bind Up the Wounds: Catholic Sister Nurses in the U.S. Civil War* 5-28  
*War and the Red Cross: The Unspoken Mission* 2-28  
*We Band of Angels* 1-28  
Brown, R., HM1, Cherry Point medical personnel recognized for hurricane Floyd support 1-1  
Brumit, Josephine, LCDR, NC, Achieving Wellness 12  
Buckley, Emanuel Navarro, in memoriam 6-23  
Burning down of Able Med, The 5-9  
Butler, R., LT, MC, Cherry Point medical personnel recognized for hurricane Floyd support 1-1
- CAMPBELL, J.R., CAPT, MSC, developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1  
Campman, S., MAJ., USAF, MC, Armed Forces Institute of Pathology collaborates to improve body armor 2-6  
Case report, high altitude medicine 1-25  
Cherry Point medical personnel recognized for hurricane Floyd support 1-1  
Children, NMC Portsmouth opens first military children's emergency unit 2-1  
Chosin Reservoir, Frozen in memory: recalling Chosin Reservoir 6-14  
Clipson, D., HM2, Cherry Point medical personnel recognized for hurricane Floyd support 1-1  
Collins, P.M., CAPT, NC, USNR  
book review  
*A History of the U.S. Army Nurse Corps (Studies in Health, Illness, and Caregiving)* 3-28  
Combat corpsmen national war memorial 5-21  
Competence to make medical treatment decision 2-21  
Conrad, Robert Dexter Award, Navy researcher awarded highest honor for scientific achievement 1-6
- Continuing debate over hospital ships, the 3-21  
Corwin, A.L., CDR, MSC, developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1
- D-DAY, The 6th Naval Beach Battalion in France, Presidential Unit Citation awarded 56 years later 6-8  
Davey, Kenneth C., The 6th Naval Beach Battalion in France, Presidential Unit Citation awarded 56 years later 6-8  
Demaio M., CDR, MC, USNR, Armed Forces Institute of Pathology collaborates to improve body armor 2-6  
Developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1  
DNA, Navy researcher awarded highest honor for scientific achievement 1-6  
Donahue, Daniel S., A new lease on life: the first U.S. Naval Hospital Washington, DC 6-5  
Duren, Rod, Blue Angels chemistry and 'Cresting' give corpsmen yellow-gear mentality, and C/MC reason to brag 6-4  
Navy medical team helps keep Blue Angels flying 6-1
- EWORS, developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1
- FLIGHT vest, pilots: close your eyes and fly! 3-1  
Foster, C.A., LT, MSC, developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1  
Frozen in memory: recalling Chosin Reservoir 14
- GINCHEREAU, E.H., CAPT, MC, USNR, Navy medicine in the forgotten war, Korea 1950-1953, Part I 3-4  
Navy medicine in the forgotten war, Korea 1950-1953 Part II 4-6



- Gravity, space sickness: the effects of weightlessness on the human immune system 2-16
- Gray, D.P., LCDR, MSC, Navy medicine's "spring fling" 2-12
- Great Lakes nurse brings pet therapy to patients 5-5
- Great Lakes Reserve and active medical commands host combat trauma symposium in Chicago 3-26
- Grillo, H., M.D., a surgeon remembers Korea 4-16
- Guzman, R., LCDR, MSC, what shall replace hospital ships? 1-9
- HAM, Ann, Armed Forces Institute of Pathology collaborates to improve body armor 2-7
- Hart, S.E., CAPT, MC, new medical department flag selections 5-7
- Hearing loss: new approaches to a persistent problem 3-15
- Herman, J.K., the last hundred years of Navy medicine 1-14
- World War II video series underway 4-4
- High altitude medicine: case report 1-24
- Hoffman, S.L. CAPT, MC, Navy researcher awarded highest honor for scientific achievement 1-6
- Hospital ships, the continuing debate over hospital ships 3-21
- what shall replace hospital ships? 1-9
- HPS, medical readiness training just in time 2-24
- Human Patient Simulator, medical readiness training just in time 2-24
- Hurricane Floyd, Cherry Point medical personnel recognized for hurricane Floyd support 1-1
- IMAGES of Korea 3-7, 4-10
- In Memoriam, CAPT Emanuel Navarro Buckley, MSC (Ret.) 23
- KENT, D.C., CAPT, MC, USN (Ret), the burning down of Able Med 5-9
- Kernal blitz prime, Navy medicine's "spring fling" 2-12
- Korea
- a surgeon remembers Korea 4-16
- frozen in memory: recalling Chosin Reservoir 14
- Navy medicine in the forgotten war: Korea 1950-1953 Part I 3-4
- Navy medicine in the forgotten war: Korea 1950-1953 Part II 4-6
- out of corpsmen: a physician remembers Inchon 5-22
- quiet heroes: Navy nurses of the Korean War 4-24
- the burning down of Able Med 5-9
- LARASATI, W., developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1
- Last hundred years of Navy medicine, the 1-14
- Lavender, D.R., LCDR, MSC, Navy medicine's "spring fling" 2-12
- Leadership changes hands at the National Naval Medical Center 2-4
- Litvin, H., M.D.
- out of corpsmen: a physician remembers Inchon 5-22
- frozen in memory: recalling Chosin Reservoir 6-14
- Lunchtime with the Admiral: a memoir 5-12
- MALARIA, Navy researcher awarded highest honor for scientific achievement 1-6
- Mandel, L. CDR, MC, USNR, lunchtime with the Admiral: a memoir 5-12
- Martin, K.L., RADM, NC, leadership changes hands at the National Naval Medical Center 2-4
- Mateczun, J.M., CAPT, MC, new medical department flag selections 5-7
- McCarthy, M., CDR, MC, developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1
- Medical readiness training just in time 2-24
- Medical students contribute to research efforts at Navy's Peru laboratory 1-2
- Military Recruit Healthcare Symposium 2000 1-27
- Mills, P.D., LT, MSC, developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1
- Montgomery, J.R., CAPT, MC, medical readiness training just in time 2-24
- NAMRU-2, developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1
- Naval Medical Center clinicians pilot violence prevention program at local school 3-16
- Naval Medical Research Center, new Army-Navy medical research facility supports Sailors, Marines, Soldiers, and Airmen 2-8
- Naval Medical Research Center Detachment medical students contribute to research efforts at Navy's Peru laboratory 1-2
- Navy medicine at war video series continues 6-24
- NAVSEA hosts hearing symposium 3-14
- Navy medical team helps keep Blue Angels flying 1
- Navy medicine at war video series continues 6-24
- Navy medicine in the forgotten war: Korea 1950-1953 Part I 3-4
- Navy medicine in the forgotten war: Korea 1950-1953 Part II 4-6
- Navy medicine's "Spring Fling" 2-12
- Navy researcher awarded highest honor for scientific achievement 1-6
- Navy trauma training: progress report: Part I 6-19
- New Army-Navy medical research facility supports Sailors, Marines, Soldiers, and Airmen 2-8
- New lease on life: the first U.S. Naval hospital Washington, DC 6-5
- New medical department flag selections 5-6
- NMC Portsmouth opens first military children's emergency unit 2-1
- NMRC, new Army-Navy medical research facility supports Sailors, Marines, Soldiers, and Airmen 2-8
- NMRC, medical students contribute to research efforts at Navy's Peru laboratory 1-2
- OLLIVIER, J.E., LT, MSC, USNR, space sickness: the effects of weightlessness on the human immune system 2-16
- Omori, F., CDR, USN, Quiet Heroes: Navy nurses of the Korean War 4-24
- Out of corpsmen: a physician remembers Inchon 5-22
- PERU, medical students contribute to research efforts at Navy's Peru laboratory 1-2
- Pilots: close your eyes and fly! 3-1
- Portsmouth, NMC Portsmouth opens first military children's emergency unit 2-1
- Pressley, M., LCDR, MC, Cherry Point medical personnel recognized for hurricane Floyd support 1-1
- Putri, M., developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1
- QUENCHING Venezuela's thirst: a dispatch from Joint Task Force Fundamental Response 4-1
- Quiet Heroes: Navy nurses of the Korean War 4-24
- RALSTON, M., CDR, MC, USNR, NMC Portsmouth opens first military children's emergency unit 2-1
- Roberts, L.H., CDR, MC, Navy trauma training: progress report: Part I 6-19
- Rupert, A.H., CAPT, MC, pilots: close your eyes and fly! 3-2

Russell, W., LCDR, MC, medical readiness training just in time 2-24

Ryan, D.M., developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1

Medical students contribute to research efforts at Navy's Peru laboratory 1-5

Navy researcher awarded highest honor for scientific achievement 1-8

New Army-Navy medical research facility supports Sailors, Marines, Soldiers, and Airmen 2-11

Pilots close your eyes and fly! 3-1

SCHILKE, P., MAJ, USAF, MC, Armed Forces Institute of Pathology collaborates to improve body armor 2-6

Sforza, Kevin, leadership changes hands at the National Naval Medical Center 2-4

Simanjuntak, C.H., developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1

6th Naval Beach Battalion in France: Presidential Unit Citation awarded 56 years later 6-8

Skills erosion, medical readiness training just in time 2-24

Smith, A.M., CAPT, MC, USNR (Ret.), the continuing debate over hospital ships 3-21

Society of Civil War Surgeons 6-25

Space sickness: the effects of weightlessness on the human immune system 2-16

Spatial disorientation, pilots: close your eyes and fly! 3-1

Surgeon remembers Korea 4-16

TACTILE Situation Awareness System pilots: close your eyes and fly! 3-2

Talmadge, S., LCDR, MSC, competence to make medical treatment decisions 2-21  
Training, Navy trauma training: progress report: Part I 6-19

Trauma, Navy trauma training: progress report: Part I 6-19

TSAS, pilots: close your eyes and fly! 3-2

U.S. Naval Medical Research Unit No. 2, developing regional outbreak response capabilities Early Warning Outbreak Recognition System (EWORS) 5-1

Uniform requirements: Navy Nurse Corps 1925 1-12

VENEZUELA, quenching Venezuela's thirst: a dispatch from Joint Task Force Fundamental Response 4-2

Vieira, J.F., CAPT, CHC, USNR, NAVSEA hosts hearing symposium 3-14

Vollbrecht, R., HM3, Cherry Point medical personnel recognized for hurricane Floyd support 1-1

Von Lubitz, D.K.J.E., Ph.D., MD, medical readiness training just in time 2-24

WEIGHTLESSNESS, space sickness: the effects of weightlessness on the human immune system 2-16

What shall replace the hospital ships? 1-9

White, A.A., LTJG, MSC, USNR, quenching Venezuela's thirst: a dispatch from Joint Task Force Fundamental Response 4-1

WOOD, F.H., MAJ, MC, USA, Naval Medical Center clinicians pilot violence prevention program at local school 3-16

Woofert, D.D., CAPT, DC, new medical department flag selections 5-8

World War II video series underway 4-4

NOTE: Figures indicate the issue and page in Volume 91 of *Navy Medicine*. For example 3-2 show the article may be found in issue No. 3 (May-Jun 2000), page 2.

\* \* \*

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